DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445108	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **05/06/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MURFREESBORO	**420 N UNIVERSITY ST** **MURFREESBORO, TN 37130**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS During the follow up survey conducted on 05/06/2019, all previously cited deficiencies were corrected.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	445108	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MURFREESBORO	420 N UNIVERSITY ST MURFREESBORO, TN 37130

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K 000	INITIAL COMMENTS Stories: 2 w/ partial basement Construction Type: II Constructed: 1958, 1970, 1976, 1982 Sprinkled: yes Census: 153 Certified beds: 161 A Life Safety Code Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 3/20/19 following a survey by the Tennessee Department of Health state survey agency on 2/25/19. At this survey, NHC Healthcare, Murfreesboro was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 43 483.70(a) and 483.70(b), Life Safety from Fire, and the related National Fire Protection Association (NFPA) publications, the 2012 edition of NFPA 101 Life Safety Code and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3 and TIA 12-4 and the 2012 edition of NFPA 99 Health Care Facilities Code and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6.	K 000	The plan of correction is submitted as required under State and Federal law and does not constitute on admission on the part of the facility that the findings cited are accurate. The findings constitute a deficiency, or that the scope and severity regarding the deficiencies cited are correctly applied. PoC Accepted 4/22/2019 Kurtis D. Grant	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372	1. The Maintenance Director repaired the smoke barrier wall in the corporate conference room and repaired the 1" diameter hole in the wall to maintain the smoke and 1/2 hour fire resistance of smoke barrier required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Foster
TITLE: Adm. Director
(X6) DATE: 4/11/19

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	445108	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MURFREESBORO	420 N UNIVERSITY ST MURFREESBORO, TN 37130

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K 372	Continued From page 1 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to maintain the smoke and ½ hour fire resistance of smoke barriers per the requirements of: 2012 NFPA 101 Sections 19.3.7.3, 8.5, 8.5.6 The deficiency affected one of five smoke barriers on the first floor. Findings include: On 3/20/19 at 10:30 a.m., the smoke barrier wall at the corporate conference room had a 1" diameter hole in the wall. The Director of Maintenance provided a plan of the building which identified the wall as a smoke barrier. The Director of Maintenance was present with the Administrator in Training when the deficiency was identified.	K 372	2. Maintenance audited smoke barrier wall on 3/21/19 with no other issues identified. 3. Maintenance reviewed the Life Safety NFPA 101 (2012 Edition) Sections 19.3.7.3, 8.5, 8.5.6. Smoke Barriers shall be constructed to a 1/2 hour fire resistance rating per 8.5. 4. Ongoing monitors will be performed by Maintenance quarterly on preventive maintenance rounds. Any findings will be brought to the QA committee for follow up as indicated.	3/21/19

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POC#1	445108	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MURFREESBORO	420 N UNIVERSITY ST MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Stories: 1 Construction Type: NFPA, II (111) No plans available on site Constructed: 1950's-1960's Sprinklered: Yes Certified beds: 161 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 02/25/2019. During this Life Safety Survey, NHC Healthcare, Murfreesboro was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). *Paperwork was provided showing the facility audited the AMANA PTAC units located throughout the facility and the repairs made. *All sprinklers deficiencies shall be corrected in accordance with NFPA 13, Standards for the Installation of Sprinkler Systems (2010 Edition) and/or NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition)	K 000	The plan of correction is submitted as required under State & Federal law and does not constitute an admission on the part of the facility that the findings cited are accurate, the findings constitute a deficiency, or that the scope & severity regarding the deficiencies cited are correctly applied.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be	K 222	The Maintenance Director removed the pad lock with a safety hasp on the outside of the door securing the oxygen storage tank room on 2/28/19.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Foote
TITLE: Administrator
(X6) DATE: 3/11/19

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K 222	Continued From page 1 equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised	K 222	The Maintenance Director installed a new door knob with a locking key system. A chain was attached to the wall beside the door with the key to unlock the door. The Director of Maintenance will ensure compliance that all doors have a means of egress that is approved.	2/28/19

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K 222	Continued From page 2 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on an observation, the facility failed to ensure that all doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side. This deficiency affects 1 smoke compartment and any resident, staff member, or visitors that may enter the oxygen storage room. The findings include: Observation on 02/25/2019 at 6:17 AM, revealed a padlock with a safety hasp on the outside of the door securing the oxygen storage room. NFPA 101, 19.2.2.2.4 (2012 Edition) The maintenance director was present for the findings, which were later acknowledged by the administrator during the exit conference on	K 222		

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K 222	Continued From page 3 02/25/2019.	K 222		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain the fire sprinkler system. This deficiency affected all smoke compartments and any resident, staff, or vistor in the building. The findings include: Document review on 02/25/2019 between 5:06 AM and 6:15 AM, revealed no fire line back flow preventer inspection since 2016. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 24.6.1	K 353	Johnson Controls was contacted by The Director of Maintenance. 3/5/19 the company Presented the service work order. On 3/7/19 the service work was signed for the company to install 2 backflow preventers, one on each fire sprinkler system. riser #1 will have a new backflow installed vertically below the 6" alarm value. riser #2 will have The backflow device installed horizontally with the main drain line being reworked to make it fit. The backflows will have butterfly shut off and will be double detector checks, as is required by Murfreesboro Water. The Maintenance Director will ensure compliance with the sprinkler system.	4/13/19

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K 353	Continued From page 4 (2010 Edition), NFPA 25, 13.6.2.1 (2011 Edition) The maintenance director was present for the findings, which were later acknowledged by the administrator during the exit conference on 02/25/2019.	K 353		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923	The 2 unsecured oxygen bottles were removed 2/25/19 immediately from the clean linen room by the Director of Maintenance. The Director of Maintenance ensured that oxygen bottles will be stored appropriately.	2/25/19

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K 923	Continued From page 5 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly store oxygen cylinders. This deficiency affected 1 smoke compartment and any resident, staff member, or visitor that uses the clean linen closet. The findings include: Observation on 02/25/2019 at 6:15 AM, revealed 5 oxygen bottles being stored in the clean linen room by room 156. NFPA 101, 19.3.2.4 (2012 Edition), NFPA 99, 5.1.3.3.2 (2012 Edition) Observation on 02/25/2019 at 6:15 AM, revealed 2 unsecured oxygen bottles being stored in the clean linen room by room 156. NFPA 101, 19.3.2.4 (2012 Edition), NFPA 99 11.3.2.1 (2012 Edition) The maintenance director was present for the findings, which were later acknowledged by the administrator during the exit conference on 02/25/2019.	K 923		

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E 000	Initial Comments During the emergency preparedness survey conducted on 02/25/2019, no deficiencies were cited.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Tosh
TITLE: Administrator
(X6) DATE: 3/11/19

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